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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ROBERT JOHN URQUHART** **aka ROBERT ARQUHART** 4647 Gerona Way Santa Barbara, CA 93110 Registered Nurse License No. 517782 Respondent.	Case No. 2012-34 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (Board).

2. On or about November 27, 1995, the Board issued Registered Nurse License No. 517782 to Robert John Urquhart aka Robert Arquhart (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 118, subdivision (b), provides that the suspension, expiration, surrender or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . ."

7. Section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section

11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. Section 2764 provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), the Board may renew an expired license at any time within eight (8) years after the expiration.

REGULATORY PROVISIONS

9. California Code of Regulations, title 16, section 1442 states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. California Code of Regulations, title 16, section 1443 states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

11. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY

12. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES / DANGEROUS DRUGS

13. Norco, hydrocodone and acetaminophen, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(e)(4) and is categorized as a dangerous drug

according to section 4022.

14. Percocet, oxycodone and acetaminophen, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1), and is categorized as a dangerous drug according to section 4022.

FIRST CAUSE FOR DISCIPLINE

(False Records)

15. Respondent is subject to disciplinary action under section 2761, subdivision (a), and 2762, subdivision (e), on the grounds of unprofessional conduct, in that on or between November 6, 2008 and November 11, 2008, while on duty as a registered nurse at Cottage Rehabilitation Hospital (RISB) at Santa Barbara Cottage Hospital, Santa Barbara, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other record pertaining to controlled substances for patients, as follows:

a. On or about November 8, 2008, RISB pharmacy identified Respondent for withdrawing an abnormal amount of five (5) Percocet at one time for a patient, and on an attending physician's complaint that Respondent was over-medicating his patients. RISB initiated an audit of Respondent's AcuDose[1] and MAR records for two (2) patients.

b. Patient G.P. On or about November 7 through 11, 2008, Respondent failed to account for two (2) Norco and thirteen (13) Percocet tablets in any hospital records.

1) On or about November 7 through 10, 2008, physician's medication orders were Norco 1 tablet every 4 hours as needed, and Percocet 1-2 tablets every 3 hours as needed. On or about November 11, 2008, physician's medication orders were Norco 1 tablet every 3 hours as needed, and Percocet 1-2 tablets every 3 hours as needed.

2) On or about November 7, 2008, at 2344 hours, Respondent withdrew two (2) Percocet tablets for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for two (2) Percocet in any hospital records.

[1] AcuDose-Rx is an automated medication dispensing cabinet.

3) On or about November 8, 2008, at 0345 hours, Respondent withdrew two (2) Percocet tablets for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for two (2) Percocet in any hospital records.

4) On or about November 8, 2008, at 0620 hours, Respondent withdrew five (5) Percocet tablets for the patient, an amount greater than authorized by three (3) tablets. Respondent recorded on the patient's MAR that the medication was administered, assumingly a maximum of two (2) tablets as ordered because he routinely fails to document the tablet numbers of the medications administered to his patients. Respondent failed to record administration, wastage or return of three (3) Percocet tablets in hospital records. Furthermore, immediately after the 0620 withdrawal, at 0623, the AcuDose records Respondent withdrawing one (1) Percocet, and at 0624, the AcuDose records Respondent returning one (1) Percocet with a witness. Respondent failed to account for three (3) Percocet in any hospital records.

5) On or about November 9, 2008, at 0155 hours, Respondent withdrew one (1) Norco tablet for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for one (1) Norco in any hospital records.

6) On or about November 9, 2008, at 0040 hours, Respondent withdrew two (2) Percocet tablets for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for two (2) Percocet in any hospital records.

7) On or about November 9, 2008, at 0317 hours, Respondent withdrew two (2) Percocet tablets for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for two (2) Percocet in any hospital records.

8) On or about November 10, 2008, at 2323 hours, Respondent withdrew one (1) Norco tablet for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records.

Respondent failed to account for one (1) Norco in any hospital records.

9) On or about November 11, 2008, at 0235 hours, Respondent withdrew two (2) Percocet tablets for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for two (2) Percocet in any hospital records.

c. Patient A.M. On or about November 6 through 11, 2008, Respondent failed to account for six (6) Norco and two (2) Percocet tablets in any hospital records.

1) On or about November 6 through 11, 2008, physician's medication orders were Oxycontin CR 10mg (1 tablet) by mouth every 12 hours, Norco 10/325 or 5/235mg 1 tablet by mouth every 3 hours as needed, and Percocet 5/325 mg 1 -2 tablets by mouth every 3 hours as needed for pain – not to exceed 4gm of APAP[2] per day.

2) On or about November 6, 2008, at 2349 hours, Respondent withdrew two (2) Percocet tablets for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for two (2) Percocet in any hospital records.

3) On or about November 7, 2008, at 0213 hours, Respondent withdrew one (1) Norco tablet for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for one (1) Norco in any hospital records.

4) On or about November 7, 2008, at 0638 hours, Respondent withdrew one (1) Norco tablet for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for one (1) Norco in any hospital records.

5) On or about November 9, 2008, at 0057 hours, Respondent withdrew one (1) Norco tablet for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records.

[2] Acetaminophen (APAP). Overdose of acetaminophen, generally considered more than 4 gm in 24 hours, may result in liver damage or failure.

Respondent failed to account for one (1) Norco in any hospital records.

6) On or about November 9, 2008, at 0536 hours, Respondent withdrew one (1) Norco tablet for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for one (1) Norco in any hospital records.

7) On or about November 9, 2008, at 2337 hours, at an unauthorized time, one (1) hour early, Respondent withdrew one (1) Norco tablet for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for one (1) Norco in any hospital records.

8) On or about November 11, 2008, at 0110 hours, Respondent withdrew one (1) Norco tablet for the patient. Respondent failed to record administration of the medication on the patient's MAR, and failed to document wastage or return of the medication in hospital records. Respondent failed to account for one (1) Norco in any hospital records.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), and California Code of Regulations, title 16, section 1442, on the grounds of unprofessional conduct, in that on or about November 6 through 11, 2008, while employed as a registered nurse at RISB, Respondent demonstrated acts of gross negligence, an extreme departure of repeated acts, as follows:

a. Respondent failed to chart medications administered, return them to the AcuDose or destroy them with a witness;

b. Respondent failed to chart exact dosages given (1 tab or 2 tabs); and

c. Respondent admitted that he failed to understand or properly utilize the AcuDose, failed to chart medications, failed to administer medications to patients by having other nurses administer medications for him, and was in fear of over-medicating patients as determined by an attending physician.

Complainant refers to and by this reference incorporates the allegations set forth above in paragraph 15, subparagraphs a – c (1 - 8), inclusive, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

17. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), and California Code of Regulations, title 16, section 1443, on the grounds of unprofessional conduct, in that on or about November 6 through 11, 2008, while employed as a registered nurse at RISB, Respondent demonstrated acts of incompetence by failing to exercise the expected degree of learning and skill that would ordinarily be expected of a competent registered nurse in safely handling and accounting for the use of controlled substances when he removed unneeded medications from the AcuDose and failed to follow procedures in returning the medications to the AcuDose or wasting them within the purview of a qualified witness. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 15 - 16, inclusive, as though set forth fully.

FOURTH CAUSE FOR DISCIPLINE

(Unlawfully Obtain / Possess Controlled Substances)

18. Respondent is subject to disciplinary action under sections 2761, subdivision (a), and 2762, subdivision (a), on the grounds of unprofessional conduct, in that on or about November 6 through 11, 2008, while employed as a registered nurse at RISB, Respondent admittedly obtained or possessed controlled substances and dangerous drugs in violation of law. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 15 - 17, inclusive, as though set forth fully.

FIFTH CAUSE FOR DISCIPLINE

(Dangerous Use of Controlled Substances)

19. Respondent is subject to disciplinary action under section Respondent is subject to disciplinary action under sections 2761, subdivision (a), and 2762, subdivision (b), on the grounds of unprofessional conduct, in that on or about November 6 through 11, 2008, while employed as a registered nurse at RISB, Respondent dangerously used controlled substances and

dangerous drugs to an extent or in a manner dangerous or injurious to himself or others and / or to the extent that such use impairs his ability to conduct with safety to the public the practice authorized by his license. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 15 - 18, inclusive, as though set forth fully.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct / Violate Act)

20. Respondent is subject to disciplinary action under section 2761, subdivision (a) and / or (d), in that Respondent committed acts of unprofessional conduct and / or violated provisions of the Nursing Practice Act. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 15 - 19, inclusive, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License No. 517782, issued to Robert John Urquhart;

2. Ordering Robert John Urquhart to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: July 18, 2011

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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